STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of a State licensure survey conducted on May 30, 2023, with document review continued through June 2, 2023, at Pittsburgh North Surgical Center. It was determined the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043		S 0043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043	Continued from page 2 51.31 Exceptions - Principle 51.31. Principle The Department may grant exceptions to this part when the policy and objectives contained therein are otherwise met, or when compliance would create an unreasonable hardship and an exception would not impair or endanger the health, safety or welfare of a patient or resident. No exceptions or departures from this part will be granted if compliance with the requirement is provided for by statute. This REGULATION is not met as evidenced by:	S 0043	POC: Chloraprep Exception An acceptable plan of correction must contain the following elements: *What corrective action will be accomplished for those residents/patients found to have been affected by the deficient practice? -Intra-operative charting now includes a comment in each patient's medical record that a visual inspection has been made and chloraprep is not soaked into the patient's hair or linens, the skin preparation solution is completely dry prior to draping. *How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken. -No other patients will be affected with proper documentation and chart audits. All aspects of the requirements in the exception report(s) will be followed and monitored by center manger. *What measures will be put into place or what systemic changes you	Completion Date: **07/21/2023** Status: **APPROVED** Date: **08/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043	Continued from page 3	S 0043	will make to ensure that the deficient practice does not recur? -Documentation that a visual inspection has been made and chloraprep is not soaked into the patient's hair or linens, the skin preparation solution is completely dry prior to draping. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -These will be monitored by the nursing staff and the Center Manager of the facility. *The plan must include the title of the person responsible for implementing the acceptable plan of correction. -Carly Mitchell, Center Manager *Include date(s) when the corrective action(s) will be completed. The corrective action completion date(s) must be acceptable and should not exceed 60 days past exit date of survey. (audits are excluded in this timeframe as it is expected that they will continue beyond 60 days to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043	Continued from page 4	S 0043	ensure compliance with PoC). -7/21/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043	Continued from page 5 Based on review of facility documents, medical records (MR), and staff interview (EMP), it was determined the facility failed to comply with the required criteria as stated in the exception granted by the Department of Health related to the requirements for 28 Pa Code § 555.31 (a), relating to anesthesia services for ten of ten medical records reviewed (MR1-MR10). Findings include: Review on May 30, 2023, at 11:45 AM, of a letter from the Department of Health to the facility dated, August 30, 2022 revealed "The facility shall ensure the skin preparation solutions, that contain combustible agents, do not soak into the patient's hair or linens. The facility shall ensure the skin preparation solution is completely dry prior to draping and shall inspect the prepped area to confirm it is dry prior to draping. ... The facility's staff shall document in the patient's medical record the above has occurred prior to the surgical procedures. ..."	S 0043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: 50861501	51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0043	Continued from page 6 Review on June 2, 2023, at approximately 12:30 PM, of facility policy "Patient Safety during Procedures" dated June 1, 2022, revealed " ... Use flammable prep solutions with caution ... All fire risk strategies must be followed. ... Do not allow prep solutions to pool around the patient. Remove any pooling of prep solutions with a towel and remove the towel from the operating room before the start of surgery. Do not allow prep solutions to pool under or around the electrosurgical pad. Do not allow flammable solutions to be absorbed into the drapes that are in contact with the patient. ..." Review on May 30, 2023, at approximately 10:40 AM, of MR1-MR10 revealed no documentation confirming the linen was not soaked with skin prep. On May 30, 2023, at approximatley 10:45 AM, EMP1 confirmed the above findings.	S 0043		
S 0110		S 0110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0110	Continued from page 7 551.21 (e)(1-3) Criteria for ambulatory surgery 551.21 Criteria for ambulatory surgery (e) In obtaining informed consent, the practitioner performing the surgery shall be responsible for disclosure of: (1) The risks, benefits and alternatives associated with the anesthesia which will be administered. (2) The risks, benefits and alternatives associated with the procedure which will be performed. (3) The comparative risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of in a hospital. This REGULATION is not met as evidenced by:	S 0110	POC: Consent An acceptable plan of correction must contain the following elements: *What corrective action will be accomplished for those residents/patients found to have been affected by the deficient practice? -A new consent has been created and approved that includes verbiage stating the patient has been explained the risks and benefits and alternatives associated with performing the procedure in the ASF instead of in a hospital. Education has been conducted with the staff for adequate knowledge of the new verbiage of the consent, as well as privileged physicians. *How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken. -No other patients will be affected with the new consent in use. The previous consent is no longer utilized. *What measures will be put into	Completion Date: **05/31/2023** Status: **APPROVED** Date: **08/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0110	Continued from page 8	S 0110	place or what systemic changes you will make to ensure that the deficient practice does not recur? -A new consent is in place containing appropriate verbiage to meet state regulations. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -These will be monitored by the nursing staff and the Center Manager of the facility. *The plan must include the title of the person responsible for implementing the acceptable plan of correction. -Carly Mitchell, Center Manager *Include date(s) when the corrective action(s) will be completed. The corrective action completion date(s) must be acceptable and should not exceed 60 days past exit date of survey. (audits are excluded in this timeframe as it is expected that they will continue beyond 60 days to ensure compliance with PoC). -5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0110	Continued from page 9 Based on review of facility policy, medical records (MR) and interview with staff (EMP), it was determined the facility failed to provide a complete informed consent for ten of ten medical records reviewed (MR1-MR10). Findings include: Review on June 2, 2023, at 10:30 AM of the facility's "Informed Consent" form, dated June 29, 2022, revealed "It is the policy of this center that all outpatient medical records must contain a properly executed and completed written informed consent form for all procedures and treatments specified by the center's medical staff and state or federal laws/regulations." Review of the consent forms for MR1-MR10 on May 30, 2023, at approximately 12:45 PM revealed the consent forms were did not include the comparative risks and benefits and alternatives associated with performing the procedure in the ASF instead of in a hospital.	S 0110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0110	Continued from page 10 During an interview on May 30, 2023, at approximately 11:00 AM, EMP2 confirmed the above findings.	S 0110		
S 6747		S 6747		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6747	Continued from page 11 567.43 Ventilation System The ventilation system shall be inspected and maintained in accordance with the written maintenance schedule to ensure that a properly conditioned air supply meeting minimum filtration, humidity and temperature requirements is provided in critical areas such as the surgical and recovery suites under Chapter 571 (relating to construction standards). This REGULATION is not met as evidenced by:	S 6747	POC: Temp/Humidity An acceptable plan of correction must contain the following elements: *What corrective action will be accomplished for those residents/patients found to have been affected by the deficient practice? -A new temp/humidity daily log has been created and approved that is currently being used to record daily temperatures and humidity levels for the monitored areas. Sections added to the log include action taken and what the recheck temp/humidity is. *How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken. -The temp/humidity log will be monitored closely by the DON as well as the Center Manager to ensure no other patients are affected by deficiency. *What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	Completion Date: **05/31/2023** Status: **APPROVED** Date: **08/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6747	Continued from page 12	S 6747	-A new log has been created and is being utilized by the RN for logging the temps and humidity and the new sections of the log will aid in facilitating the documentation when ranges are not within the parameters of the state regulations. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -These will be monitored by the DON and the Center Manager of the facility. *The plan must include the title of the person responsible for implementing the acceptable plan of correction. -Carly Mitchell, Center Manager *Include date(s) when the corrective action(s) will be completed. The corrective action completion date(s) must be acceptable and should not exceed 60 days past exit date of survey. (audits are excluded in this timeframe as it is expected that they will continue beyond 60 days to ensure compliance with PoC). -5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6747	Continued from page 13 Based on review of facility documents and interview with facility staff (EMP), it was determined the facility failed to follow facility policy and ensure that the ventilation system met the temperature requirements in operative rooms. Findings include: Review on May 30, 2023, of the facility's "Temperature and Humility Management" policy revealed "Purpose: It is the purpose of this policy to provide guidelines to ensure proper storage of sterile and clean supplies. An optimal level of temperature and humidity is met to assure sterile integrity for infection control and suppress the potential for static electricity. ... the temperature shall be between 68-73 Degrees Fahrenheit (20-22 Degrees Celsius) and recorded daily by the preop nurse in the temp/humidity log book located at the nurses station. Any corrective actions taken will be recorded on the temperature - Humidity Log in the the Center Manager log book in the comments section. ..." 1. Review on May 30, 2023, at 1:30 PM, of the	S 6747		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: 00 B. WING:	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100** **CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6747	Continued from page 14 facility humidity and temperature log revealed "Feb. 23... Room PR[Procedure Room]#2" the temperatures were below the required temperature. 2. Review on May 30, 2023, at 1:30 PM, of the facility humidity and temperature log revealed "5/23... Room #1" that the temperatures were below the required temperature on May 9, 11,17, 23, May 25, 2023. 3. Review on May 30, 2023, at approximatley 1:30 PM, of the facility humidity and temperature log revealed "5/23... Room #2" the temperatures were below the required temperature on May 1, 2, 3, 4, 5,8, 9, 10, 11, 12, 15, 16, 17, 18, 19, and May 24, 2023. 4. Review on May 30, 2023, at approximately 1:30 PM, of the facility humidity and temperature log revealed "March 2023 ... PR #2" the temperatures were below the required temperature on March 1, 2, 3, 6, 7, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, and March 31. 5. Review on May 30, 2023, at approximately 1:30 PM, of the facility humidity and temperature log	S 6747		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001377	A. BLDG: __00_____ B. WING: _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PITTSBURGH NORTH SURGICAL CENTER STATE LICENSE NUMBER: **50861501**	**51 DUTILH ROAD, SUITE 100 CRANBERRY TOWNSHIP, PA 16066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6747	Continued from page 15 revealed "April 2023 ... PR #2" the temperatures were below the required temperature on April 4, 5, 6, 7, 10, 11, 12, 13, 14, 18, 24, 26, and April 28, 2023. During an interview on May 30, 2023, at approximatley 1:15 PM, EMP1 confirmed the above and confirmed the facility temperatures were not within the temperature requirements.	S 6747		

Certified End Page

PITTSBURGH NORTH SURGICAL CENTER

STATE LICENSE NUMBER: 50861501

SURVEY EXIT DATE: 06/02/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY